The Bush budget: subverting Medicare and Medicaid

Part four of five articles on Bush's 2004 budget proposal

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This is the fourth in a series of articles on the social implications and political significance of the Bush administration's fiscal 2004 budget plan. Part one, "The Bush budget: blueprint for a right-wing assault on the working class*", was posted on February 11. Part two,* "Welfare for the wealthy: the Bush tax plan*", was posted on February 12. Part three,* "Bush budget targets the poor *", was posted on February 13. Tomorrow the WSWS will publish an analysis of the budget's implications for public education.*

In the guise of extending benefits and making programs more flexible, the Bush administration is proposing changes that would effectively undermine both Medicare and Medicaid, the two large federal health care programs that provide services to the elderly and to the poor, respectively.

Medicare will be hit by further cuts in reimbursements to providers, which will deepen their financial crisis and cause many providers to refuse Medicare patients altogether. The Medicare Payment Advisory Commission recommended a freeze on payments to nursing homes and home health care agencies and a reduction in the scheduled cost-of-living allowances for hospitals. Payments were already cut 4.9 percent to home health care agencies and 10 percent to nursing homes on October 1.

The number of people receiving such care through Medicare has dropped from 3.5 million in 1997 to 2.2 million in 2001, despite an increase in the elderly population, because agencies have cut back admissions or abandoned serving Medicare patients entirely. In most cases these are the most vulnerable of the elderly—those whose health is so poor they cannot take care of themselves without such assistance.

The most important change in Medicare, however, is Bush's proposed $400 billion plan to add a prescription drug benefit. Given that the elderly will spend an estimated $2 trillion on prescription drugs over the next 10 years, a plan on the scale of the administration's, covering only 20 percent of the projected cost, cannot be considered a serious effort to meet the social need.

Instead, the new prescription drug benefit seeks to exploit this growing problem for a political purpose. It is to be used like a wrecking ball to smash up the traditional fee-for-service plan—currently chosen by 85 percent of seniors—and force them to switch to managed care options like HMOs and PPOs that restrict their selection of doctors and allow insurance companies the final say on treatment options.

The administration has not released details of the plan, and has seemed to be backpedaling after initial protests from senior citizens and health care advocacy groups, and even some congressional Republicans.

Secretary of Health and Human Services (HHS) Tommy Thompson, in testimony February 6 before the House Ways and Means Committee, said that final decisions on how much coverage would be offered and what incentives or coercion would be applied to get Medicare recipients to leave traditional fee-for-service plans were "still being worked on." But when asked point blank if he could guarantee to the elderly that they would be able to retain fee-for-service coverage and still receive prescription drug coverage, he said he could not.

Prescription drug coverage and other benefits, such as limited coverage for catastrophic care, are to be used as an inducement for the gradual privatization of Medicare, as the elderly switch to plans administered by privately owned HMOs and PPOs rather than the traditional plan.

The drug benefit itself will be quite limited. One press account of HHS deliberations said standard prescription

drug coverage would require a deductible of $275 a year, then provide 50 percent coverage up to $3,050 a year, then no coverage to a total patient cost of $5,500 a year, then 90 percent coverage thereafter. This would leave most Medicare recipients paying thousands of dollars a year out of their own pockets for prescription drugs.

One of the most drastic and reactionary proposals in the Bush budget is a plan to do away with federal rules that apply to some one-third of Medicaid recipients, those with incomes above the federal eligibility level. States would be given complete authority to set benefit and co-payment levels for these recipients, while the federal share of this portion of Medicaid would be capped.

The plan leaves benefits intact for 29 million people covered under the basic federal plan—those of the lowest income bracket, largely consisting of the unemployed, welfare recipients and the disabled. But state governments have leveraged the Medicaid program to pay for health care for low-income workers as well, extending coverage to 15 million people with incomes slightly above the federal maximum. Under current rules, the federal government pays the bulk of these costs for "optional" recipients. This would now be changed.

The states would be given a fixed amount of Medicaid money to distribute to these recipients, and would be allowed to keep any funds left over after benefits are paid. The approach is similar to that adopted in the Clinton administration's 1996 welfare reform legislation, which gave the states a financial incentive to cut benefits and tighten eligibility requirements. The states would also be allowed to discriminate among their residents, offering different benefit packages and imposing different co-pays and eligibility standards in different counties, or forcing selected groups into managed care programs.

Since such "optional" coverage now accounts for two-thirds of total Medicaid dollars, the amount of money involved is huge—nearly $200 billion of current spending. The Bush administration would set the fixed amount for each state through a formula based on last year's spending, which will inevitably lag behind increases in health care costs and in the number of people seeking coverage as the recession worsens.

Even without this federal pressure to cut costs, 49 of the 50 states have already cut benefits for "optional" recipients or announced plans to do so. Half the states have requested federal waivers allowing them to drop coverage or increase co-pays. State governments face mounting budget deficits, an estimated $68 billion for the coming year, and for many states Medicaid is the largest single budget item.

The technique employed by the Bush administration—offering states a slight increase in Medicaid funding this year, about $3.3 billion, if they sign up for the long-term spending caps—is particularly cynical, and has outraged advocates of expanding health care coverage for the working poor.

Robert Greenstein of the Center on Budget and Policy Priorities said the administration would "hold such aid hostage to a state's agreeing to accept changes that threaten to weaken health insurance for low-income families in the future." Ron Pollack of Families USA said, "The president's proposal offers modest upfront money in a manner that is reminiscent of a loan shark. In effect, the Bush administration is forcing cash-strapped states to buy into a very bad deal so that they can receive quick money now."

Even before last month's State of the Union address, the Bush administration issued new rules that attempted to limit emergency services for poor people on Medicaid. The HHS regulation would have allowed states to set a maximum number of visits to the emergency room. It would also have suspended the current standard, that a "prudent layman" would find it necessary to go to the emergency room, requiring instead that the visit be medically necessary in the judgment of a medical professional.

These rules were rescinded abruptly five days after they were made public in press reports. The news stories provoked widespread anger and threats to introduce countervailing legislation by both congressional Democrats and Republicans.